

Evolving Site of Care Trends in the U.S. Managed Care Ecosystem

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Abstract: *In the evolving U.S. managed care ecosystem, the payer is a key entity that employs strong levers of restrictions on patient access, among which site of care is an underutilized restriction. It is important to understand site of care trends because of the strong implications they have on patients, such as higher out-of-pockets costs, greater delays in treatment, and more barriers to receiving appropriate and often live-saving care. This research therefore explores payer site of care preferences across 64 payers, 29 oncologists and 151 physicians in an attempt to understand these trends. Based on the results discussed in this research study, and as a point of future discussion, it will be important for researchers in this space to take on additional topics such as payer denials for coverage of treatments administered at a non-preferred site of care, payer preference for in-home administration compared to infusion centers, manufacturers' role in optimizing site of care, and types of infusion provider and laboratory networks for payers. Future research on these topics will support greater transparency and accountability among different stakeholders in the U.S. healthcare industry to utilize site of care in a way that benefits patients moving into the second half of this decade.*

Keywords: managed care, patient access, healthcare access, healthcare, site of care

1. Introduction

The United States healthcare infrastructure is one of the most complex systems in the world, in large part due to ever-changing relationships between providers, payers and patients. As is common with sizable and complex ecosystems, these relationships occasionally have repercussions; within U.S. healthcare, limited patient access to life-saving therapies is one such undesired side effect.

Payers are organizations such as health plan providers and government programs (Medicare and Medicaid) that use various levers to manage healthcare management and control costs, often impacting patient care. Drug tiering, for example, allows healthcare plans to place covered prescription drugs on different coverage tiers, with each tier corresponding to a determined out-of-pocket cost that patients must pay before receiving medication. While tiering should in theory be based on factors like drug cost, availability, and clinical effectiveness, in practice, generics (which are generally more affordable drugs) are increasingly being moved to more expensive—and therefore less accessible—tiers [1]. Prior authorizations (PAs) are other cost-control measures by which physicians and other health care providers must receive advance health plan authorization before a patient can receive a specific treatment [2]. While PAs can manage prescription drug costs and ensure appropriate drug use, the PA process can be time-consuming and labor-intensive, resulting in patient care delays. One of the most underexplored mechanisms—site of care (SOC)—is yet another payer lever [3].

SOC refers to instances where the administration of infusions or injections must occur at specific locations, such as stand-alone infusion centers, physician provider practices, or at home, in order to be covered. Historically, payer preference for certain sites of care was a lesser-used

technique for managing healthcare costs until recently, when the coronavirus disease (COVID-19) pandemic upended and accelerated movement of care from high-cost, post-acute sites of care to lower-cost freestanding and non-acute sites. This included a shift towards emerging home care segments, such as home infusions, home-based dialysis, primary home care, and hospital-at-home models when health systems were overwhelmed with the volume and severity of COVID-19 cases [5]–[9].

This has created momentum to further change the site of care landscape, which the proceeding research will make evident. In the years immediately following the initial COVID-19 outbreak, some of the most utilized sites of care by commercial plan members and patients for infusion therapies were in-office and freestanding infusion centers.

This research considers multiple sites of care, including: *in-office administration* (doctor's office/physician-associated clinic); *freestanding infusion center or suites* (brick-and-mortar infusion suites owned by a corporation not associated with a physician, such as a specialty pharmacy provider (SPP) or a value-added service of a SPP); *in-home administration by specialty pharmacy provider (SPP)* (an agent is administered in the patient's home by a nurse/medical professional coordinated and contracted by the SPP or belonging to a home infusion company); *in-home self-administration* (an agent is self-administered at the patient's home); and *HOPD* (hospital out-patient department).

Other important components of site of care are how these non-oncology and oncology infusion therapies are obtained and reimbursed. For example, payers manage common acquisition methods such as buy-and-bill (a healthcare provider purchases a drug and stores it for the patient until administration), brown-bagging (a specialty pharmacy

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dispenses a medication directly to a patient) and SPPs. These various methods create a continuum of accessibility and affordability for patients, often at odds with what is most financially advantageous to payers [10]. In a similar vein, payers' SOC decisions are swayed by the type of reimbursement methods for infusion or injection therapies, which include average sales price (ASP), average wholesale price (AWP), percentage of billed charges, negotiated mark-up, part of bundled payment, or wholesale acquisition cost (WAC). Understanding SOC priorities for payers, as well as common acquisition and reimbursement methods for infusion therapies, is crucial because all have far-reaching implications on the viability of the healthcare system, particularly for patients. SOC is an opportunity to address efficiency and effectiveness in patient treatment, but it is not always actuated by the patient's best interest. When payers do not cover treatments that are administered at a non-preferred site of care, for example, they are reimbursed at a higher rate while patients pay the price—a larger cost share—thus creating a greater overall administrative burden.

Payers have cited common reasons for why they do not cover such treatments, including drugs being non-formulary, having to work through non-preferred providers, step edits existing for the medication, and shipping/storage requirements creating additional difficulties, but even at preferred sites of care, payers have similar responses for why coverage is denied. Despite the opportunity for other types of denials to prohibit access, patients still have the greatest chance of accessing necessary treatments if their therapy is administered at a preferred site of care.

2. Methodology

Titles	Site of Care Dynamics (N = 35)
Medical Director / Chief Medical Officer	20%
Pharmacy Director / Clinical Pharmacist	80%
Other	0%
Organization Type	
Large National Plan	23%
Regional Affiliate of a Large National Plan	0%
Blues Affiliate	29%
Independent Plan	20%
Pharmacy Benefit Management Firm (PBM)	29%
Region	
Pacific & Northwest (AK, CA, HI, ID, OR, WA)	11%
Mountain (AZ, CO, MT, ND, NM, NV, SD, UT, WY)	0%
Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI)	6%
Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT)	11%
South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	11%
Multi-regional	9%
Large national	51%
Covered Lives	118.8 M

Figure 1: Displays the breakdown of titles, organization type, region and covered lives represented by the sample of 35 commercial payers.

Titles	Site of Care Dynamics (N = 29)
Medical Director / Chief Medical Officer	21%
Pharmacy Director / Clinical Pharmacist	79%
Other	0%
Organization Type	
Large National Plan	24%
Regional Affiliate of a Large National Plan	0%
Blues Affiliate	21%
Independent Plan	21%
Pharmacy Benefit Management Firm (PBM)	34%
Region	
Pacific & Northwest (AK, CA, HI, ID, OR, WA)	14%
Mountain (AZ, CO, MT, ND, NM, NV, SD, UT, WY)	0%
Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI)	7%
Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT)	14%
South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	3%
Multi-regional	3%
Large national	59%
Covered Lives	43.0 M

Figure 2: Displays the breakdown of titles, organization type, region and covered lives represented by the sample of 29 Medicare payers.

Practice Size	Site of Care Dynamics (N = 151)
Small practices (1-5 physicians)	39%
Mid-sized practices (6-9 physicians)	46%
Large practices (10+ physicians)	15%
Practice Affiliation	
Independent Practice: Partner	44%
Independent Practice: Non-partner	13%
Independent Hospital: Employee of Hospital	3%
Hospital Owned Health System: Employee of Health System	25%
Hospital Owned Health System: Employee of Practice	11%
Payer Owned Health System: Employee of Health System	2%
Payer Owned Health System: Employee of Practice	1%
Other	0%
Region	
Pacific & Northwest (AK, CA, HI, ID, OR, WA)	17%
Mountain (AZ, CO, MT, ND, NM, NV, SD, UT, WY)	6%
Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI)	17%
Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT)	29%
South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	32%
Representative Members of Integrated Delivery Networks (IDNs)	34

Figure 3: Displays the breakdown of practice size, practice affiliation, region and members of IDNs represented by the sample of 151 physicians.

Site of Care Definitions (Note: Information as Displayed to Respondents)
In-office administration: Patient receives the infusion or injection in a doctor's office/physician-associated infusion clinic.
Freestanding infusion center or suite: This is a brick-and-mortar infusion suite owned by a corporation and not associated with a physician. It may be owned by a Specialty Pharmacy Provider (SPP) or be a value-added service of a Specialty Pharmacy Provider (SPP).
In-home administration by specialty pharmacy provider (SPP): Agent is administered in the patient's home by a nurse/medical professional coordinated and contracted by the SPP or belonging to a Home Infusion Company.
In-home self-administration: Agent is self-administered at the patient's home
HOPD: Hospital Out-Patient Department

Figure 4: Site of care definitions

2.1 Demographics

A sample size of 64 payers, 29 oncologists and 151 physicians took part in this study. Thirty-five payer participants represented 118.8 million commercial lives, while the remaining 29 payers represented 43 million lives in the Medicare segment. Research was conducted in Q2 2023.

Eighty percent (80%) of commercial payer respondents were pharmacy directors or clinical pharmacists and 20% were medical directors or chief medical officers. Regarding organization type, 23% of commercial payers represented large national health plans, 29% represented regional plan affiliates, 20% represented independent plans, and the remaining 29% represented pharmacy benefit management firms (PBMs). In terms of regions* within the United States that payers represented, 51% of payers identified their reach as national; 11% of payers worked within the Pacific & Northwest states of the US (AK, CA, HI, ID, OR, WA); 11% within the Northeast region (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT); 11% within the South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV); 9% within multiple regions; and 6% within the Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI).

Pharmacy directors or clinical pharmacists accounted for 69% of Medicare payer respondents, medical directors/chief medical officers accounted for 23%, and 8% of participants identified as "other." Regarding the organization type, 34% of payers represented PBMs, 24% large national, 21% Blues affiliates, and 21% independent plants. In terms of regions within the United States that payers represented, 59% of payers identified their reach as large national; 14% of payers worked primarily within the Pacific & Northwest regions (AK, CA, HI, ID, OR, WA); 14% within the Northeast

region (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT); 7% within the Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI); 3% within the South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV); and 3% within multiple regions.

Physician participants representing small practices (one to five physicians) accounted for 44% of physician respondents, those representing mid-sized practices (six to nine physicians) accounted for 29% of physicians, and those representing large practices (10+ physicians) accounted for the remaining 27% of physician participants. Additionally, 34 physicians were representative members of integrated delivery networks (IDNs).

Forty-four percent (44%) of physicians were affiliated with independent practices as a partner; 25% with hospital-owned health system as an employee of the health system; 13% were non-partners at an independent practice; 11% were employees of a practice at a hospital-owned health system; 3% were independent hospital employees; 2% were employees of a payer-owned health system; and 1% were employees of a practice at a payer-owned health system.

Regionally, 31% of physicians worked within the Southern region of the United States (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV); 29% within the Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT); 17% within the Pacific and Northwest regions (AK, CA, HI, ID, OR, WA); 17% within the Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI); and 6% within the Mountain region (AZ, CO, MT, ND, NM, NV, SD, UT, WY).

3. Results

Survey results were indicative of payer and physician priorities across three areas of interest: most utilized SOC, common acquisition methods for non-oncology and oncology infusion therapies, and common reimbursement methods for non-oncology and oncology infusion or injection therapies.

3.1 Site of Care

Payers cited in-office and freestanding infusion centers as the most utilized SOC for patients receiving non-oncology infusion therapies, with an average of 25% of commercial plan members receiving treatment at each location. Similarly, physicians indicated that an average of 38% of patients received non-oncology infusion therapies in-office, making it the most utilized SOC.

For oncology infusion therapies, physicians cited that an average of 52% of patients received care in-office, while commercial payers indicated an average of 29% of commercial plan members received care in HOPDs.

In contrast, payers and physicians indicated that *in-home: specialty pharmacy provider-administered* was the least utilized SOC, with 6% of patients and 15% of commercial plan members receiving non-oncology infusion therapies at that location. For oncology infusion therapies, *in-home: self-*

administered was the least utilized SOC, with 6% of patients and 10% of plan members receiving treatment in that manner.

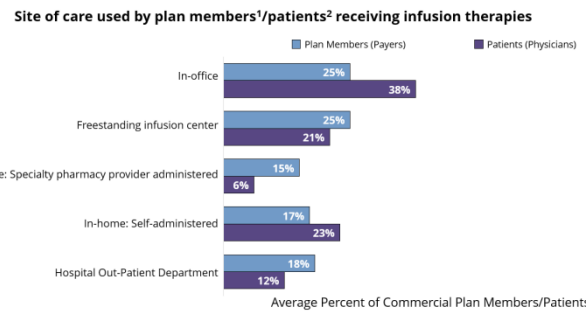


Figure 5: Most used sites of care for non-oncology infusion therapies

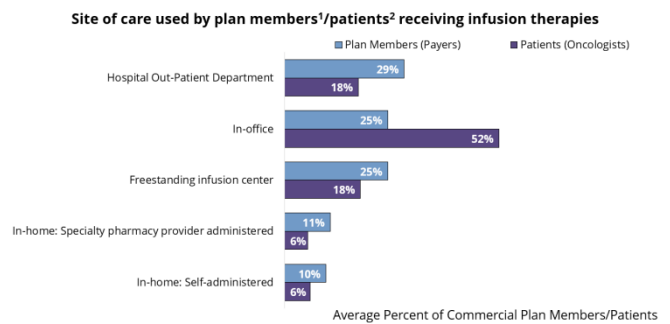


Figure 6: Most used sites of care for oncology infusion therapies

3.2 Acquisition Methods

Payers representing more than 70% of commercial lives for non-oncology infusion therapies administered in-office or at freestanding infusion centers cited buy-and-bill as the most common acquisition method utilized. Payers representing 95% of commercial lives cited SPPs as the most common acquisition method for in-home specialist pharmacy provider-administered non-oncology infusion therapies. In contrast, 5% of commercial lives cited patient acquisition (brown-bagging) as a common acquisition method for non-oncology infusion therapies, and less than 5% of lives cited buy-and-bill as a common acquisition method for therapies administered in-home by a specialty pharmacy provider.

Payers representing more than 80% of commercial lives for oncology infusion therapies administered in-office or at freestanding infusion center cited buy-and-bill as the most common acquisition method for treatment. Payers representing 88% of commercial lives cited SPP as the most common acquisition method for in-home specialist pharmacy provider-administered for oncology infusion therapies. Thirty-four percent (34%) of lives cited brown-bagging as the most common acquisition method for in-home, self-administered oncology infusion therapies, and 7% cited brown-bagging as the most common acquisition method for in-home, specialty pharmacy provider-administered oncology infusion therapies.

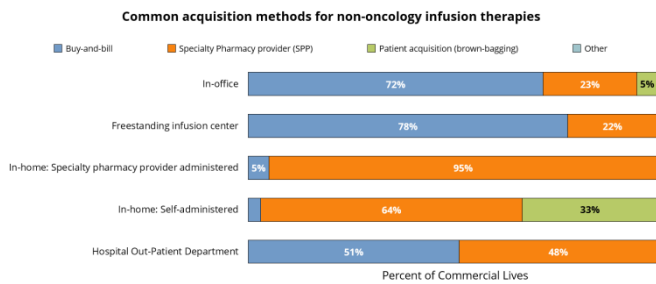


Figure 7: Common acquisition methods for non-oncology infusion therapies

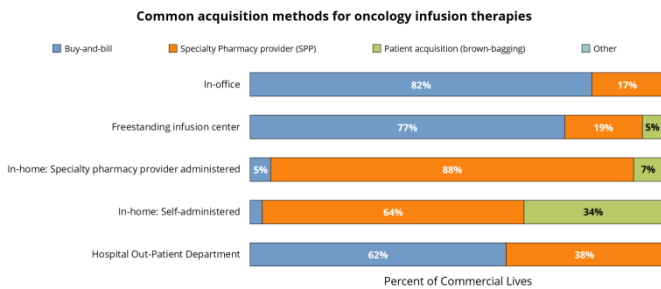


Figure 8: Common acquisition methods for oncology infusion therapies

3.3 Reimbursement Methods

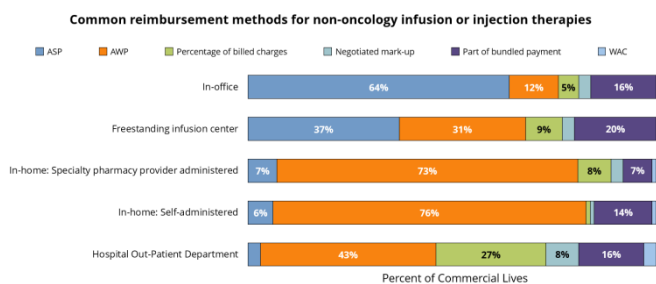


Figure 9: Common reimbursement methods for non-oncology infusion or injection therapies

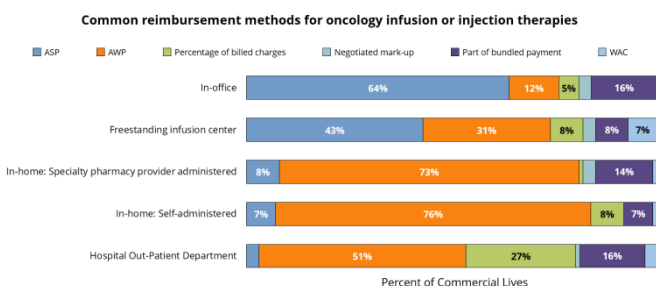


Figure 10: Common reimbursement methods for oncology infusion or injection therapies

For both non-oncology and oncology specialty products administered in-office, 64% of commercial lives cited average sales price (ASP) as the most common reimbursement method for infusion or injection therapies. Similarly, average wholesale price (AWP) reimbursement was the prevailing method used for in-home, self-administered and SP provider-administered drugs for non-oncology and oncology specialty products. Specifically, 73% of commercial lives cited AWP reimbursement as the prevailing reimbursement method used for SP provider-administered drugs, and 76% of commercial lives cited AWP as the most common reimbursement method for self-administered therapies.

In contrast, only 5% of commercial lives for both oncology and non-oncology infusion or injection therapies administered in-office cited the percentage of billed charges as the most common reimbursement method, while 16% of lives identifying “part of bundled payment” as the most common reimbursement method for the same SOC.

Fifty-one percent (51%) of commercial lives for oncology infusion or injection therapies administered at HOPD noted AWP as the prevailing reimbursement method, while 43% of Commercial lives for non-oncology cited the same.

4. Discussion

Other topics that will be critical to explore in 2024 to further evaluate these trends will be payer coverage denial of treatments administered at a non-preferred site of care, payer preference for in-home administration compared to infusion centers, manufacturers’ role in optimizing site of care, and types of infusion provider and laboratory networks for payers.

5. Conclusion and Future Scope

Early indicators suggest that in the coming year, at least one-third of payers will continue to prefer in-office administration, while more than one-third of physicians will continue to prefer in-office administration. Physicians have a more pronounced preference for freestanding infusion centers than payers, and payers have more of a preference for in-home, self-administered compared to physicians. Payers will continue to favor hospital outpatient departments the least, and physicians will do the same for in-home, SPP-administered therapies.

For these high-cost therapies, it is also important to consider the perspective of the physician. Physicians anticipate that most of their patients will, by early 2024, shift from their current SOC utilization. Physicians are generally optimistic when it comes to how payers should be open to influencing patients’ shifting SOC treatment, but there is reason to be hesitant that this change will not occur. The reasons for this may be that payers may not cover treatment administered at a non-preferred SOC, payers may reimburse at higher rates when agents are administered at their preferred SOC, and patients may pay a higher cost-sharing for receiving those agents at non-preferred SOC.

While physicians and payers have differing opinions on the importance of site of care and anticipated usage in 2024, the role of pharmaceutical manufacturers will become key in terms of ensuring education on white-bag processing, broad pharmacy access, continuation of easy-to-administer drugs, investing in provider and patient education, and continuing research and development for self-administered drugs.

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Appendix

United States regions:

Pacific & Northwest (Alaska, California, Hawaii, Idaho, Oregon, Washington)

Northeast (Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont)

South (Alabama, Arkansas, Washington D.C., Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia)

Midwest (Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Montana, Missouri, Nebraska, Wyoming)

Mountain region (Arizona, Colorado, Montana, North Dakota, New Mexico, Nevada, South Dakota, Utah, Wyoming)

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